



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Alleged Deficiencies in
Mental Health Care Prior to
a Death by Suicide at the VA
San Diego Healthcare
System

California



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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to a hotline complaint alleging that staff at the San Diego VA Healthcare System (system), California, failed to provide mental health care to a patient who subsequently died by suicide. The OIG identified additional concerns for review including the quality of the suicide risk assessment, decision-making process to deactivate the High Risk for Suicide Patient Record Flag (PRF), adequacy of resident supervision, and adequacy of the medication reconciliation process.

The OIG did not substantiate that the system failed to provide mental health care when the patient sought help. The patient first sought care at the system in spring 2017. The patient was referred to mental health services and intermittently engaged in care with an outpatient psychiatrist and outpatient psychologist. The patient engaged in diagnostic testing with a system psychologist and was followed by a suicide prevention coordinator from summer 2017 to spring 2018. When the patient sought mental health services in the emergency department in summer 2018, a psychiatry resident conducted an assessment, and offered medication management and treatment options. The patient declined voluntary inpatient psychiatric admission, expressed feeling safe to go home, and was discharged home with a follow-up care plan. The patient's outpatient psychiatrist attempted to reach the patient by telephone subsequent to the emergency department visit.

The OIG found that the suicide risk assessment of the patient was adequate and complied with Veterans Health Administration (VHA) and system requirements. Upon presenting to the emergency department, the triage nurse immediately assessed for risk of suicide and placed the patient on one-to-one constant observation. The psychiatry resident conducted the required Clinical Suicide Risk Assessment including assessment of firearms access.

The system complied with VHA and the system's policy regarding resident supervision, supervision documentation, and monitoring of resident supervision documentation. The psychiatry resident documented consultation with the supervisory psychiatrist. The supervisory psychiatrist indicated review and concurrence with the resident provided care through co-signature on the progress note. The system Health Information Management Service demonstrated compliance with quarterly supervision documentation audits, quarterly audits demonstrated meeting the expected compliance rate, and results of audits were reported to the Medical Executive Committee.

The OIG identified deficits in the decision-making process to deactivate the patient's High Risk for Suicide PRF. The assigned Suicide Prevention Coordinator chose to deactivate the patient's High Risk for Suicide PRF in spring 2018 without contacting the patient, without consulting the patient's treatment team, without the patient having any scheduled future appointments, and despite the patient having not been engaged in any mental health services for more than two

months. VHA does not have clearly delineated requirements for the decision-making process to deactivate the High Risk for Suicide PRF; however, the Executive Director, Suicide Prevention Program told the OIG that there is an expectation that the suicide prevention coordinator will consult with the patient's treatment team, provide evidence of decreased risk and reduced suicide risk factors, and document rationale for clinical judgment about mental health conditions and behaviors.

The OIG determined that there were deficits in the medication reconciliation process and documentation. Per system policy, the emergency department pharmacist conducted a partial medication reconciliation with the patient prior to discharge from the emergency department; however, there was no evidence that the emergency department pharmacist reviewed all medications with the patient and the documentation failed to indicate that the patient self-discontinued two of the active medications on the imported medication list.

The OIG made one recommendation to the Under Secretary for Health related to management of High Risk for Suicide PRFs and one recommendation to the System Director related to the medication reconciliation process and documentation.¹

Comments

The Executive in Charge, and the Veteran Integrated Service Network and System Directors concurred with the recommendations and provided acceptable action plans. (See appendixes A, B, and C pages 21–25 for the Executive in Charge and Directors' comments.) The OIG considers both recommendations open and will follow up on the planned and recently implemented actions to ensure that they have been effective and sustained.



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¹ The recommendation directed to the Under Secretary for Health (USH) was submitted to the Executive in Charge who has the authority to perform the functions and duties of the USH.

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Abbreviations

CSRA	Comprehensive Suicide Risk Assessment
CSRE	Comprehensive Suicide Risk Evaluation
EHR	electronic health record
MRC	Medical Record Committee
OIG	Office of Inspector General
PEC	Psychiatric Emergency Clinic
PRF	Patient Record Flag
SPC	suicide prevention coordinator
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to determine the validity of an allegation that a patient sought help at the VA San Diego Healthcare System (system), “was turned away,” and subsequently completed suicide.

Background

The system, part of Veteran Integrated Service Network (VISN) 22, is located in San Diego, California, and operates six community based clinics located in Chula Vista (Chula Vista Clinic), Escondido (Escondido Clinic), El Centro (Imperial Valley Clinic), Oceanside (Oceanside Clinic), and San Diego (Mission Valley Clinic, Rio Clinic, and Sorrento Valley Clinic). VA classifies the system as Level 1a—High Complexity.² In fiscal year 2018, the system served 84,712 patients and had a total of 272 operating beds, including 164 inpatient beds, 69 domiciliary beds, and 39 community living center beds. The system provides medical, surgical, mental health, geriatric, spinal cord injury, and advanced rehabilitation services. The system has 296 authorized beds, including skilled nursing beds, and operates several regional referral programs including cardiovascular surgery and spinal cord injury. Three Vet Centers in Chula Vista, San Diego, and San Marcos are supported by the system. The University of California, San Diego School of Medicine is affiliated with the system and provides training for 1,383 medical interns, residents and fellows, as well as 738 other clinical trainees, in areas such as nursing, pharmacy, dental, and dietetics.

Suicide Prevention

Suicide is the tenth leading cause of death in the United States. A 2018 VA national study found that veteran and non-veteran adult suicide rates increased from 2005 to 2016.³ From 2015 to 2016, the overall veteran suicide rate decreased from 30.5 to 30.1, while the suicide rate for veterans ages 18–34 increased from 40.4 to 45, respectively.⁴ In 2016, the suicide rate was 1.5 times higher for veterans than non-veterans when controlling for factors such as age and gender.⁵ The most frequent methods utilized to complete suicide among male veterans were firearms

² The VHA Facility Complexity Model categorizes medical facilities by complexity level based on patient population, clinical services offered, educational and research missions, and administrative complexity. Complexity Levels include 1a, 1b, 1c, 2, or 3. Level 1a facilities are considered the most administratively complex. Level 3 facilities are the least complex. VHA Office of Productivity, Efficiency and Staffing. (The website was accessed April 4, 2019, and is an internal VA website not publicly accessible.)

³ VA National Suicide Data Report 2005-2016, Office of Mental Health and Suicide Prevention, September 2018.

⁴ For purposes of this report, suicide rate is defined as the number of deaths per 100,000 veterans; VA National Suicide Data Report 2005-2016.

⁵ VA National Suicide Data Report 2005-2016.

(70.6 percent), suffocation (14.8 percent), and poisoning (9.7 percent). Female veterans utilized firearms (41.2 percent), poisoning (30.4 percent), and suffocation (19.8 percent) most frequently.⁶

Suicide Risk Assessment

VHA requires that all staff receive suicide risk and intervention training.⁷ A patient at high acute risk for suicide should be assessed in an emergency setting and the system director is responsible for ensuring that all emergency department staff receive suicide prevention training.⁸ The emergency department director and manager are responsible for ensuring that all patients presenting to the emergency department are screened for suicide risk and that the system suicide prevention coordinator (SPC) is informed of any patient presenting with suicidal ideation.⁹ In consultation with a psychiatric provider, the emergency department attending provider determines the appropriate level of care for a patient presenting with suicidal ideation, including voluntary or involuntary admission to an inpatient mental health unit, or discharge to home with follow-up instructions.¹⁰

VHA suicide risk assessment and prevention guidelines include standardized screening questions and an in-depth evaluation and assessment of suicide risk when screenings are positive.¹¹ Clinical practice guidelines suggest an assessment of the availability of, access to, or intent to acquire firearms to determine a patient's risk for suicide.¹² On September 20, 2018, the Deputy Under

⁶ VA National Suicide Data Report 2005-2016.

⁷ VHA Directive 1071, *Mandatory Suicide Risk and Intervention Training for VHA Employees*, December 22, 2017.

⁸ VA/DoD, The Assessment and Management of Risk for Suicide Working Group, VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide, Version 1.0 – June 2013; VHA Directive 2010-008, *Standards for Mental Health Coverage in Emergency Departments and Urgent Care Clinics in VHA Facilities*, February 22, 2010. This VHA directive was rescinded and replaced on September 2, 2016, by VHA Directive 1101.05(2), *Emergency Medicine*, amended on March 7, 2017. The 2016 directive contained the same or similar language concerning emergent mental health care.

⁹ In 2007, VHA required facilities to establish a full-time SPC role designated to implement suicide prevention strategies via education, data collection, and coordination of care. VHA defined the SPCs' responsibilities to include clinical coordination, staff education, and administrative oversight. VA Deputy Under Secretary for Health for Operations and Management, Memorandum—*Mental Health Funding for Suicide Prevention Coordinators*, February 8, 2007; VHA Directive 2010-008.

¹⁰ *California Code, Welfare & Institutions Code §5150* allows a person deemed a danger to self or others or gravely disabled to be held for 72 hours for evaluation and treatment; San Diego VA Healthcare System, Policy 11-95, *Involuntary Detention at VA San Diego Healthcare System*, January 30, 2018.

¹¹ VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide, Version 1.0; VA Deputy Under Secretary for Health for Operations and Management, Memorandum—*High Risk for Suicide Patient Record Flag Changes*, October 3, 2017.

¹² VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide, Version 1.0.

Secretary for Health for Operations and Management announced implementation of a standardized Comprehensive Suicide Risk Evaluation (CSRE) template that was to be fully implemented across VHA no later than October 1, 2018.¹³ The Chief of Performance Improvement Management Services told the OIG that the system implemented the CSRE template on “approximately” October 1, 2018. Prior to the nationally implemented CSRE, each facility used its own version of a Comprehensive Suicide Risk Assessment (CSRA) template. System staff utilized the CSRA to identify and document specific characteristics and environmental factors that may have increased or decreased a patient’s risk for suicide and to provide an estimated risk level.¹⁴ The system’s templated CSRA identified patient risk factors such as suicidal ideation, history of self-harm behaviors, preparatory behaviors, lethal means access including firearms, substance abuse behaviors, and protective factors such as treatment engagement, and support of family and friends. The CSRA results in an estimated risk level of nil, low risk, moderate/ambivalent,¹⁵ or high risk/imminent and lists corresponding provider options for interventions, such as hospitalization and patient agreement to limit lethal means access.¹⁶

For a patient assessed at moderate or high risk for suicide, a clinician, in conjunction with the patient, will develop a safety plan and provide a copy of the plan to the patient.¹⁷ The safety plan is a templated form that includes individualized coping strategies as well as contact information of supportive individuals and resources that patients can access to help lower an elevated risk of suicidal behavior.¹⁸ The safety plan also includes ways to reduce access to lethal means, and other information focused on supporting the patient during a crisis.¹⁹

High Risk for Suicide Patient Record Flags

VHA established the High Risk for Suicide Patient Record Flag (PRF) to alert staff to patients with immediate clinical safety concerns and is therefore only activated for those patients assessed at high risk for suicide and only for the duration of the increased risk. The SPC is responsible for collaboration with the patient’s treating clinicians to determine if a High Risk for

¹³VA Deputy Under Secretary for Health for Operations and Management, Memorandum—*Update to Suicide Risk Screening and Assessment Requirements*, September 20, 2018.

¹⁴ San Diego VA Healthcare System Policy 11-24, *Identification, Assessment, and Management of Veterans at Risk for Suicide*, December 2, 2016.

¹⁵ System policy defines a moderate/ambivalent suicide risk level as a patient with “multiple risk factors with few protective factors; suicidal ideation with plan but no expressed intent or behavior.” San Diego VA Healthcare System Policy 11-24.

¹⁶ San Diego VA Healthcare System Policy 11-24.

¹⁷ San Diego VA Healthcare System Policy 11-24.

¹⁸ VA, *Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version*, August 20, 2008.

¹⁹ VA, *Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version*.

Suicide PRF should be placed.²⁰ If a patient is determined to be at high risk for suicide, the SPC must activate a High Risk for Suicide PRF in the patient’s electronic health record (EHR) within 24 hours after determining that one is indicated.²¹ The system SPC is responsible for managing the High Risk for Suicide PRFs, assessing the risk of suicide in individual patients in conjunction with treating clinicians, maintaining a list of patients flagged, establishing a system of High Risk for Suicide PRF reviews at least every 90 days, and identifying suicide prevention training needs.²² The System Director is responsible for ensuring that the SPC (1) reviews High Risk for Suicide PRFs every 90 days and (2) deactivates the PRF when the patient no longer presents an elevated risk.²³

VHA requires the High Risk for Suicide PRF to be “promptly removed when the high-risk status is resolved,” but does not define a process or provide guidelines for the deactivation of PRFs.²⁴ In February 2019, the Executive Director, Suicide Prevention Program told the OIG that there is a policy in development to set expectations about the PRF deactivation process. The Executive Director also said that the decision to deactivate a PRF should not be made solely by the SPC and that the SPC should consult with the interdisciplinary team to determine if a patient’s high risk for suicide status is resolved.

Residency Supervision

VHA training facilities must adhere to the standards of the Accreditation Council for Graduate Medical Education.²⁵ The Accreditation Council for Graduate Medical Education requires that there is an identified attending physician who is responsible for each patient receiving care from a resident. The attending physician is responsible for the patient care that the resident provides and must maintain “a personal involvement” in the care. The level and intensity of supervision is determined by both the experience and competency of the resident and the complexity of the

²⁰ For the purposes of this report, clinicians include licensed independent providers and registered nurses. VA Deputy Under Secretary for Health for Operations and Management, Memorandum - *High Risk for Suicide Patient Record Flag Changes*; VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010. This VHA Directive expired December 31, 2015 and has not been renewed; San Diego VA Healthcare System Policy 11-69, *Patient Record Flags*, April 1, 2018.

²¹ VA Deputy Under Secretary for Health for Operations and Management, Memorandum - *High Risk for Suicide Patient Record Flag Changes*; VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008. This directive expired July 31, 2013, and has not yet been renewed.

²² VHA Directive 2008-036.

²³ VHA Directive 2008-036.

²⁴ VHA Directive 2008-036.

²⁵ VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012. This handbook was scheduled for recertification on or before the last working day of December 2017 and has not been recertified. The Accreditation Council for Graduate Medical Education sets residency and fellowship medical education programs and institutions. The institution must comply with those standards to be accredited.

patient's needs.²⁶ Supervision can be provided through various methods including direct or indirect supervision and oversight.²⁷ An attending physician supervisor is responsible for supervision of residents involved in specialty consultation services, such as psychiatry, in the emergency department. Residents must contact the attending physician while the patient is still in the emergency department to discuss the case and develop a recommended plan of management.²⁸

VHA requires monitoring of resident supervision to improve and enhance documentation. To adequately document resident supervision, the attending physician can enter a separate progress note, add an addendum to the resident's progress note, or co-sign the resident's progress note. Alternatively, the resident can document a summary of the discussion with the attending physician and a statement of the supervising practitioner's oversight responsibility to the progress note. The System Director must ensure that a resident supervision monitoring system is established.²⁹ System policy requires quarterly resident EHR audits to ensure documentation of supervisory practitioner involvement including the "presence, timeliness, authentication, readability, quality, consistency, clarity, accuracy, completeness."³⁰ A system Medical Record Committee (MRC) subcommittee conducts quarterly audits and the MRC reports the results to the Medical Executive Committee bi-annually.

Medication Reconciliation

VHA established a medication reconciliation process to maintain and communicate accurate patient medication information by identifying, addressing, and documenting discrepancies between the medication list found in the EHR and the patient's verbal report.³¹ Accurate medication information can reduce the risk of injury, particularly for patients who receive care from multiple providers or patients who receive multiple medications. The medication reconciliation process is to occur at every episode of care or change in care level in which medications will be administered, ordered, modified, or may affect the care given. The completion of a medication reconciliation includes taking information from the patient,

²⁶ VHA Handbook 1400.01.

²⁷ Direct supervision is when the attending physician is physically present with the resident and patient. Indirect supervision is when the attending physician is immediately available to provide direct supervision either physically or by telephone or other electronic means. Oversight is when the attending physician reviews and provides feedback after the resident-provided care is delivered.

²⁸ VHA Handbook 1400.01.

²⁹ VHA Handbook 1400.01.

³⁰ VA San Diego Healthcare System Policy 11E-12, *Monitoring of Health Professions Trainee Supervision*, January 20, 2016.

³¹ VHA Directive 2011-012, *Medication Reconciliation*, March 9, 2011. This directive expired March 31, 2016 and has not been updated.

comparing it to the EHR medication list, updating the EHR medication list, communicating and providing education to the patient, and communicating to VA or non-VA providers.

VHA providers with prescription privileges, including pharmacists, are responsible for following the local VA policy regarding medication reconciliation.³² System policy indicates that objects imported into the EHR must be reviewed and corrected both at the source and in the documentation if found to be incorrect.³³ An MRC subcommittee is responsible for ensuring that templated content is compliant with system policies. The medication reconciliation process includes a comparison of the patient's EHR medication list with the patient's report of medications taken. The system policy has additional requirements:³⁴

- Attending physicians to be responsible for appropriate supervision of residents and to ensure that discharge instructions are consistent with information in the EHR.
- Prescribing providers' adherence to the system policy and documentation of a plan to address discrepancies.
- Pharmacists to consult with the provider as needed for medication management of the patient.
- A partial medication reconciliation for care provided in the emergency department, when the only change is new, short-term medications.³⁵

Allegations and Related Concerns

On August 7, 2018, the OIG received a complaint alleging that system staff denied care to the patient and that the patient subsequently died by suicide. On August 16, 2018, the Office of Healthcare Inspections (OHI) Hotline Workgroup reviewed the patient's care and on October 9, 2018, accepted the complaint as a hotline. This inspection addressed the original allegation:

1. The system failed to provide care when the patient sought help and the patient subsequently died by suicide.

³² VA San Diego Healthcare System Policy 11-27, *Medication Reconciliation*, June 21, 2017.

³³ VA San Diego Healthcare System Policy 11-22, *Electronic Entry of Medical Record Information*, June 21, 2017.

³⁴ VA San Diego Healthcare System Policy 11-27.

³⁵ For a partial medication reconciliation, the outpatient medication list is imported into an EHR progress note, reviewed with the patient, and staff provides the patient with an updated list.

Further, the inspection team reviewed the following concerns identified by the OHI Hotline Workgroup and the OIG inspection team including the

2. Quality of the psychiatry resident's suicide risk assessment,
3. SPC's decision-making process to deactivate the patient's High Risk for Suicide PRF,
4. Quality of the medical resident's supervision, and
5. Medication reconciliation process.

Scope and Methodology

The OIG initiated the inspection on October 24, 2018, and conducted a site visit January 8 through January 10, 2019.

The OIG team reviewed VHA directives and handbooks, system policies and procedures, and Accreditation Council for Graduate Medical Education guidelines in effect in summer 2018 related to suicide prevention, mental health treatment, resident supervision, EHR documentation, and medication reconciliation. The OIG team also reviewed relevant empirical literature, committee meeting minutes, and documentation audits.

The OIG team reviewed the patient's EHR for the period spring 2017 through summer 2018, the patient's Veterans Choice Program (Choice) provider's medical records, and the County of San Diego Medical Examiner's Autopsy Report.³⁶ The OIG team conducted interviews with the Executive Director, Suicide Prevention Program and VHA's Implementation Lead for the Suicide Prevention Program, system leaders, and employees familiar with the residency training program, the suicide prevention program, and the patient's care. In addition, OIG team members toured the emergency department and spoke to the emergency department staff who were knowledgeable about the events at issue.

The OIG inspection team attempted to contact the complainant by telephone, certified mail, and electronic mail; however, the complainant did not respond.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

³⁶ The Veterans Choice Program is one of the ways VA provides community care to veterans. Community providers must meet eligibility requirements and establish a contract with VA's third-party administrator to become Choice providers.

Patient Case Summary

The patient was in their 20s at the time of death by suicide.³⁷ The patient first experienced depressive symptoms including insomnia and thoughts of suicide during high school but did not seek treatment at that time. The patient entered the military in 2013 and began meeting with a counselor one month later because of “feeling really depressed.” The patient chose not to start medication until summer 2014 due to concerns that it might interfere with military training. At that time, the patient was prescribed two antidepressant medications and a sleep aid.

The patient sought mental health treatment almost two years after military discharge during an initial visit with a system primary care provider in spring 2017. During that visit, the patient complained of periodic thoughts of self-harm. The patient asked to restart psychiatric medications and the primary care provider prescribed an antidepressant. The primary care provider also submitted a mental health consult. Approximately ten days later, a social worker completed a mental health intake. The patient described chronic passive suicidal ideation and a strangulation attempt (placement of a belt around the neck) while in the military though the patient reportedly removed the belt and called the “suicide hotline.” The social worker completed a suicide risk assessment and the patient admitted to researching methods of suicide on the internet. The social worker estimated the patient’s risk of suicide to be moderate/ambivalent. The patient did not think a safety plan would be useful and declined to complete one.

Six weeks after the initial primary care provider visit, the patient met with a system outpatient psychiatrist. The patient described trouble falling asleep and noted that the antidepressant had not had significant effect. The patient agreed to the addition of another antidepressant to help with low mood and poor concentration, and a medication at bedtime as needed for insomnia. The psychiatrist diagnosed the patient with multiple mental health conditions.

During the next psychiatry visit two weeks later, the patient informed the psychiatrist about stopping the prescribed medications due to side effects. The patient agreed to start a different antidepressant. The psychiatrist urged the patient to contact the system psychologist to begin psychotherapy. Within another two weeks, the patient indicated interest in trying an antipsychotic medication. The psychiatrist educated the patient about mental health conditions, and added an antipsychotic medication to help with antidepressant effect and mood lability.

In early summer 2017, the patient reported neutral mood, improved sleep, and the initiation of psychotherapy with a Choice provider. Almost three weeks later, the patient reported taking the antipsychotic medication but discontinued the antidepressant due to weight gain concerns. The psychiatrist prescribed a different antidepressant and a sleep aid as needed. At a follow-up visit two weeks later, the psychiatrist noted that the patient’s mood seemed lower than usual. The

³⁷ The OIG uses the singular form of they in this instance for privacy purposes.

patient described researching methods of suicide on the internet, specifically regarding pain associated with different methods. The patient denied current thoughts of suicide and was able to describe multiple ways to seek help in crisis. The psychiatrist increased the antidepressant dose and the antipsychotic medication dose to help with the patient's low mood. The patient gave the psychiatrist permission to contact the Choice provider. The patient rescheduled the psychiatry follow-up appointment multiple times. The psychiatrist called the patient approximately three weeks after the increase in the patient's medications. The patient reported intrusive thoughts of suicide and planned to discuss them with the Choice provider. The patient denied active suicidal ideation, intent, or plans.

Less than a week later, the psychiatrist called the patient's Choice provider. They agreed that although the patient did not meet criteria for inpatient psychiatric admission, the patient was at long-term elevated risk for self-harm. During a follow-up psychiatric visit four days later, the patient admitted to a suicide attempt mid-summer 2017. After a friend did not respond to a request for a call, the patient attempted strangulation with a plastic bag but removed the bag after one minute. The patient denied researching suicide methods since that event and denied active thoughts of self-harm at the visit. The psychiatrist and patient reviewed a safety plan and the psychiatrist referred the patient to the SPC for a high risk for suicide evaluation. The psychiatrist reviewed the patient's treatment plan with the mental health treatment team which resulted in a recommendation for psychological testing to differentiate diagnoses. A psychology intern completed a psychological evaluation of the patient in late summer 2017.

The day after the psychology intern evaluation, the patient saw the psychiatrist and admitted to substance use three weeks earlier. The psychiatrist documented patient impulsivity, limited insight, and limited awareness of consequences of actions taken. The patient admitted to passive thoughts of death but denied suicidal ideation. The patient did not want to include family in treatment.

Approximately two weeks after the psychology intern evaluation, the SPC contacted the patient who reported fleeting suicidal ideation and denied suicidal plans. The patient expressed awareness of crisis services and a preference to reach out to friends if they were available. The patient missed a scheduled follow-up psychiatry appointment two days later, but left personal journal writings for the psychiatrist. The next day, the psychiatrist and patient met and discussed the patient's journal writings about death and the patient denied intent or plan to self-harm or hurt others. The psychiatrist continued the antidepressant medication, increased the antipsychotic medication dosage, and added antianxiety medication. When the SPC called the patient approximately one week later, the patient was future oriented and reported recent enrollment in college.

The patient transferred psychotherapy care from the Choice provider to a system psychologist. In fall 2017, the patient described fleeting thoughts of suicide and thoughts of harming others, but denied any intent. The psychologist assessed the patient's suicide risk as moderate/ambivalent.

The patient was seen the same day by an Addictions Disorder Treatment Program therapist, but the patient did not feel the need for addictions treatment. The following day, the patient told the psychiatrist about substance use since the last visit and the psychiatrist offered the addition of a medication to help with cravings.

One week later, the patient and the psychologist developed a new safety plan, and the patient received a copy of the safety plan. The psychologist assessed the patient's suicide risk as high. At another visit with the psychology intern and supervisory psychologist the next week, the patient was provided with testing feedback related to the patient's mental health conditions. The patient was evaluated by both the psychiatrist and the psychologist the following week. The patient reported discontinuing the antipsychotic medication and denied suicidal thoughts to the psychiatrist. When speaking with the psychologist, the patient wondered about a need to take medications at all. One month later, the Lead SPC continued the patient's High Risk for Suicide PRF.

After several missed appointments, the patient met with the psychologist in early winter 2017 and reported increased substance use and dropping out of school due to low motivation.³⁸ Later that month, the patient described mood as average and reported fleeting thoughts of suicide without plans or intent to the psychologist. The following week, the patient told the psychologist about no longer taking the prescribed psychiatric medications because the patient felt they were no longer needed. Additionally, the patient wished to have one final psychotherapy session due to improvements in mood. The psychologist documented the patient's suicide risk as moderate/ambivalent and included the psychiatrist as an additional signer on the note. The next week, the patient saw the psychiatrist who encouraged the patient to restart the antidepressant medication and had a last session with the psychologist; the patient reported that increased substance use contributed to an improved mood and maintained that medication was no longer needed.

In early 2018, the psychiatrist reached the patient by phone after the patient missed an appointment. The patient said that two weeks prior, while at an airport, the patient texted a picture to a friend that depicted a belt around the patient's neck, and then turned the phone off. The friend contacted the patient's family who called airport security. The patient said that the police spoke with the patient upon landing but did not detain the patient. During the phone call, the patient denied suicidal ideation and reviewed crisis numbers with the psychiatrist. Three days after the phone call, the patient agreed to an intensive outpatient program referral, but declined the psychiatrist's offers for substance abuse treatment or restarting psychiatric medication.

After the patient missed the next appointment, the psychiatrist contacted the system emergency department social worker, who called police and requested a health and welfare check. During

³⁸ Due to reported illness, the patient canceled two appointments and failed to appear for one appointment. The clinic canceled one appointment due to provider unavailability.

the health and welfare check, the patient expressed passive thoughts of death but did not meet criteria for inpatient admission. The patient agreed to follow up with the outpatient providers the following week but did not. After multiple calls to the patient without response, the psychiatrist called the patient's mother (listed as the patient's emergency contact) and left a voice message. The patient's mother called back and said that she was speaking with the patient twice a week and was appreciative of staff concern.

In late winter 2018, the SPC contacted the patient, and the patient reported decreased depression, and decreased frequency and intensity of suicidal thoughts. The SPC changed the patient's suicide risk assessment to moderate/ambivalent. The SPC made additional calls to the patient approximately 30 and 45 days later, without making contact. The patient's suicide risk flag was deactivated in late spring 2018.

The patient presented to the system emergency department in summer 2018, shortly after 11:00 p.m. with thoughts of suicide by self-inflicted gunshot. The emergency department nurse assessed the patient one hour after arrival; a second-year psychiatry resident evaluated the patient about three hours after arrival. The psychiatry resident described the patient as "pleasant, engaging, and jovial at times," despite the patient's self-report of feeling suicidal for the prior two days after a fight with a friend. The patient denied symptoms consistent with major depressive disorder including changes in appetite, energy, or concentration but admitted having fleeting thoughts of suicide most days of the week.

The resident offered the patient voluntary psychiatric admission for stabilization, but the patient declined. The patient stated that the conversation with the resident had improved the patient's mood and the patient now felt safe to return home with a roommate. The patient declined the resident's offer to contact the patient's roommate. The resident and patient discussed the benefits of treatment, and the patient agreed to allow the resident to contact the patient's outpatient psychiatrist to re-establish mental health treatment. The resident documented that the patient's presentation did not meet criteria for involuntary admission or "warrant psychiatric inpatient admission at that time."

The resident's note included a plan for the patient to follow up in the Psychiatry Emergency Clinic (PEC) within five days for re-evaluation, as well as to present to the PEC or the emergency department or to call the crisis line if the patient experienced suicidal or homicidal ideation or medication side effects. The resident noted that the patient was "short-term future oriented to following up" in the PEC the day after emergency department discharge.³⁹ The resident assessed the patient's short-term risk of suicide as low based on the patient's denial of suicidal ideation, short-term future orientation, and stated religious beliefs, but acknowledged

³⁹ The system PEC provides mental health services for patients who are not enrolled in a mental health clinic, have not seen their mental health provider in 24 months, or require immediate mental health services. There is an urgent care section for walk-in patients.

that the patient's long-term risk of suicide was elevated given the patient's history of chronic suicidality and other mental health conditions. The patient requested medication for sleep and the resident provided a five-day supply of a non-habit forming sleep aid.

The resident documented that the resident and attending psychiatrist discussed the patient and the attending psychiatrist agreed with the plan. The emergency department pharmacist completed a medication reconciliation with the patient. The patient left the system emergency department approximately five hours after arrival. The staff psychiatrist cosigned the resident's consult note within four hours of the patient's discharge. The resident added the outpatient psychiatrist, outpatient psychologist, and Lead SPC to the note as additional signers. The outpatient psychiatrist was not scheduled to work until four days after the patient presented to the emergency department. The outpatient psychiatrist reviewed and signed the resident's emergency department note the day after returning to work.

The outpatient psychiatrist attempted to contact the patient by phone after signing the resident's note, and left a voicemail message requesting the patient return to care. A psychiatry medical support assistant attempted to reach the patient by phone seven and eight days later. Since the call was unsuccessful, the medical support assistant sent a letter to the patient on the day of the second unsuccessful phone call, that encouraged the patient to call to schedule an appointment and noted that there would be no further attempts to schedule an appointment. The patient expired two days after the medical support assistant sent the letter. The Deputy Medical Examiner reported the patient's cause of death as asphyxia (suffocation) and manner of death as suicide.

Inspection Results

1. Provision of Mental Health Care

The OIG team did not substantiate the allegation that system staff did not provide care when the patient sought help. The patient first sought mental health treatment in spring 2017. From spring 2017 through summer 2018, the patient engaged in mental health services including suicide prevention, psychotherapy with a Choice provider and then a system psychologist, and outpatient psychiatric treatment. In late 2017, the patient informed the outpatient psychologist about stopping all psychiatric medications and no longer wanting individual therapy. The patient missed an appointment with the outpatient psychiatrist in early 2018. Following the missed appointment, the outpatient psychiatrist attempted to reach the patient the same day, contacted the SPC, and reached out to the patient's emergency contact. System staff made multiple unsuccessful attempts to reach the patient between late winter 2018 and mid-spring 2018.

At the time of the emergency department visit in summer 2018, the patient presented with suicidal ideation to the system emergency department nurse. Emergency department staff placed the patient on one-to-one observation, consistent with VHA requirements.⁴⁰ The emergency department attending physician evaluated the patient and placed a consult to psychiatry. A psychiatry resident evaluated the patient, completed a suicide risk assessment, and offered the patient inpatient psychiatric admission for stabilization, which the patient declined. The resident documented that the patient denied suicidal intention or plan and felt safe to return home. The patient was discharged from the emergency department after approximately five hours with a discharge plan and recommendations that included a five-day sleep aid supply, follow up with the PEC within five days, and with the patient's outpatient psychiatrist. The resident included the patient's outpatient psychiatrist, outpatient psychologist, and the Lead SPC as additional signers on the emergency department progress note. Review of the EHR indicated that the patient did not present to the PEC as recommended in the discharge follow-up plan.

Five days after the emergency department discharge, the patient's outpatient psychiatrist attempted telephone contact and left a voicemail message encouraging the patient to call and re-establish care. A medical support assistant was unable to contact the patient by telephone and mailed a letter. The patient died by suicide two days after the letter was sent.

⁴⁰ VHA defines one-to-one observation as the constant monitoring of one patient by one staff member. Staff providing one-to-one observation have no other duties during the assignment.

2. Quality of the Psychiatry Resident's Suicide Risk Assessment

The OIG concluded that the resident screened the patient for suicide risk, as required by VHA.⁴¹ Consistent with clinical practice guidelines, the resident further documented evaluation of the patient's past suicide attempt, current mood and affect, medications, and history of mental health treatment.⁴² The resident completed the CSRA including all key elements. The resident listed the patient's protective factors including the patient's religious beliefs, good relationship with a clinician, motivation for treatment, and family and friend support. The resident assessed the patient's acute risk for suicide as low based on the patient's denial of suicidal ideation, intent or plan, and short-term future orientation, and protective factors. The resident noted that the patient was at chronic elevated risk for suicide due to underlying psychiatric conditions and limited coping skills.

The patient expressed feeling safe to return home and declined the resident's offer of a voluntary inpatient psychiatric admission. The resident determined that the patient did not meet criteria for involuntary psychiatric admission. The resident and patient agreed on a follow-up plan including re-establishing care with the outpatient psychiatrist to discuss intensive outpatient treatment and presenting to the PEC within five days. Additionally, the resident engaged the patient in safety planning to manage possible decline in mood and future suicidal ideation.

Firearms Assessment

The OIG found that the resident adhered to clinical practice guidelines and assessed the patient's access to firearms. The resident documented the patient's plan to "shoot self" and that the patient did not own firearms or have firearms in the home, did not have access to firearms, and did not have knowledge of how to obtain a firearm.

3. Deficiencies in the Decision-Making Process to Deactivate the Subject Patient's High Risk for Suicide Patient Record Flag

The OIG determined that in spring 2018, the Lead SPC administratively deactivated the patient's High Risk for Suicide PRF at the request of the assigned SPC. VHA requires that the High Risk for Suicide PRF be deactivated "as soon as clinically indicated." VHA policy does not provide guidance regarding the clinical indication criteria or process for deactivation.⁴³ In February 2019,

⁴¹ VHA Directive 2010-008, *Standards for Mental Health Coverage in Emergency Departments and Urgent Care Clinics in VHA Facilities*, February 22, 2010. This VHA directive was rescinded and replaced on September 2, 2016, by VHA Directive 1101.05(2), *Emergency Medicine*, amended on March 7, 2017. The 2016 directive contained the same or similar language concerning suicide risk screening.

⁴² VA/DoD, The Assessment and Management of Risk for Suicide Working Group, VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide, Version 1.0 – June 2013.

⁴³ VHA Directive, 2008-036, *Use of PRF to Identify Patients at High Risk for Suicide*, July 18, 2008. This VHA Directive expired July 31, 2013 and has not been updated.

the Executive Director, Suicide Prevention Program told the OIG that the expected process for deactivation of High Risk for Suicide PRFs included the SPC's consultation with the patient's treatment team, evidence of reduced suicide risk factors, and clinical judgment about mental health conditions and behaviors. In addition, the SPC Implementation Lead reported that standards for deactivation of High Risk for Suicide PRFs were being developed.

Despite the assigned SPC's last contact with the patient occurring over two months earlier and the absence of recent or future appointments with outpatient providers, the assigned SPC did not contact the patient or consult with outpatient providers regarding the patient's status, appropriate outreach, or the advisability of the High Risk for Suicide PRF deactivation. As such, the assigned SPC's determination of the criteria for deactivation of the High Risk for Suicide PRF was not based on current status of clinical indicators including the patient's mental health condition and suicide risk factors.

In summer 2017, the outpatient psychiatrist completed the CSRA and assessed the patient's suicide risk as "high risk or imminent" and noted the patient's reported self-harm behaviors. The Lead SPC activated a High Risk for Suicide PRF the next day. The assigned SPC spoke with the patient by phone the next month. The patient endorsed occasional suicidal ideation and denied any plan or intent to act on thoughts. The assigned SPC telephoned the patient in late 2017 and early 2018, and the patient did not report any distress or safety issues. Approximately two weeks after the 2018 contact with the SPC, the patient informed the outpatient psychiatrist over the telephone about recent self-harm behaviors and denied any current active suicidal ideation. On that same day, the Lead SPC completed a suicide behavior report and documented the patient's reported self-harm incident, as outlined by system policy.⁴⁴

The next week, the outpatient psychiatrist documented that the patient reported passive suicidal ideation during the previous week and denied current suicidal or homicidal ideations. The patient then missed appointments with the outpatient psychiatrist and psychologist; neither provider was able to reach the patient by phone. At the outpatient psychiatrist's request, a social worker contacted the police department to conduct a health and welfare check. The health and welfare team reported that the patient acknowledged passive suicidal ideation, but upon evaluation, did not meet criteria for an involuntary admission.⁴⁵ The outpatient psychologist attempted to contact the patient on the day of the missed appointment, two days later, and eight days later, leaving messages offering a new appointment without any returned calls from the patient. During this time, the Lead SPC continued the patient's PRF and planned to re-evaluate the PRF 90 days later. After the third unsuccessful attempt to reach the patient, the outpatient psychiatrist left the

⁴⁴ VA San Diego Healthcare System, Policy 11-24, *Identification Assessment and Management of Veterans at Risk for Suicide*, December 8, 2016.

⁴⁵ California Code, Welfare & Institutions Code §5150.

patient's mother a message; the patient's mother contacted the psychiatrist later that day to report that the patient was doing well.

Approximately a month later, the assigned SPC attempted, but did not reach the patient by telephone and documented that the patient did not have any scheduled future appointments. Over the next several weeks, other unsuccessful attempts to reach the patient included a primary care medical support assistant sending a letter to the patient due to unsuccessful primary care provider scheduling attempts and the assigned SPC leaving two telephone voicemails for the patient.

In spring 2018, the assigned SPC electronically mailed the Lead SPC and requested that the Lead SPC deactivate the patient's High Risk for Suicide PRF. The assigned SPC noted review of the patient's EHR and that the last documented contact was a late winter phone call and at that time, the patient reported "doing okay," with increased activity, decreased depression, and fleeting suicidal ideation. The assigned SPC noted that the patient "is followed by Primary Care and Psychiatry."⁴⁶ However, the patient's last primary care appointment was a year earlier in spring 2017 and last psychiatry appointment was in early 2018. The patient did not have any scheduled primary care or psychiatry appointments. One week later, the Lead SPC deactivated the patient's High Risk for Suicide PRF and included the patient's primary care provider and outpatient psychiatrist as additional signers on the EHR notification note; both the primary care provider and the outpatient psychiatrist acknowledged receipt of the notification.⁴⁷ In an interview with the OIG, the outpatient psychiatrist did not recall being consulted in the decision-making process to deactivate the patient's PRF.

The failure to seek current information about the patient's mental health status or obtain guidance from treating providers, rendered it unlikely that the SPC could make an informed decision about the patient's risk level. As such, the decision to deactivate the PRF was not based on current relevant information about the patient's suicide risk level and therefore did not comply with VHA's requirement for PRF deactivation upon resolution of risk. It is possible that if staff outreach occurred in spring 2018, the patient may have re-engaged in care, the PRF may have continued, and the monitoring of the patient would have been more intensive.

4. Quality of Medical Resident Supervision

The OIG found that system staff complied with VHA and system requirements for resident supervision, supervisory documentation, and monitoring of supervisory documentation.

The resident's consultative note entered at the time of the summer 2018 emergency department visit included a statement that the resident discussed the patient with the attending psychiatrist and that the attending psychiatrist agreed with the plan. The attending psychiatrist cosigned the

⁴⁶ The assigned SPC left VHA employment and the OIG was unable to interview the former employee.

⁴⁷ The patient's primary care provider signed the note two days after the deactivation and the outpatient psychiatrist signed the note three days after the deactivation.

resident's note four hours after the resident completed the note. In an interview with the OIG team, the resident confirmed discussing the patient and plan with the attending psychiatrist by telephone, as required by VHA. In an interview with the OIG team, the attending psychiatrist did not recall the telephone call specifically but expressed certainty that the discussion occurred as indicated by the attending psychiatrist's co-signature on the resident's note.

The OIG found that the system's quarterly resident supervision documentation audits for the period of September 2017 through November 2018 consistently exceeded the 90 percent compliance level benchmark. The MRC reviewed the quarterly audit results and reported to the Medical Executive Committee in the Biannual MRC Executive Summary, as required by VHA.

5. Deficiencies in the Medication Reconciliation Process

The OIG team found that the emergency department pharmacist did not fully comply with VHA and system medication reconciliation requirements.⁴⁸ Specifically, the medication reconciliation note included medications that the patient had discontinued as active medications.

The resident documented that the patient had discontinued two prescribed medications and was not interested in restarting medication. During an interview with the OIG team, the resident acknowledged that the patient's discontinuation of medication was discussed with the attending psychiatrist and that the outpatient provider was aware of the medication non-adherence. The resident did not document rationale for continuing the two medications as active prescriptions or a discussion with the patient about discontinuing the medication prescriptions; however, the resident did document discussion with the patient regarding follow up with the outpatient psychiatrist.

The emergency department pharmacist told the OIG team that there was a consultation with the psychiatry resident and that the resident's note indicated that the patient was not taking some medications. The emergency department pharmacist did not document reviewing all outpatient medications with the patient. The partial medication reconciliation note automatically imported the outpatient medication list into the EHR note. The OIG team identified that the information on the medication reconciliation note was not accurate. The emergency department pharmacist provided the medication list with all medications listed as active to the patient upon discharge. The emergency department pharmacist told the OIG team that the medication reconciliation note should have included that the patient self-discontinued medications.

⁴⁸ VHA Directive 2011-012; VA San Diego Healthcare System, Memorandum 11-22, *Electronic Entry of Medical Record Information*, June 21, 2017.

Conclusion

The OIG did not substantiate that the system failed to provide care to the patient when the patient sought care. Beginning in spring 2017, the patient engaged with outpatient mental health services intermittently. In summer 2018, the patient presented to the emergency department with suicidal ideation. A psychiatric resident evaluated the patient and offered several treatment options. The resident informed outpatient providers of the patient's emergency department care through the EHR and the outpatient providers subsequently made several attempts to contact and re-engage the patient in treatment.

The OIG found that the suicide risk assessment and resident supervision were adequate and complied with VHA and local requirements. The psychiatry resident conducted the required CSRA including assessment of firearms ownership, access, and knowledge of access. The system complied with VHA and system policy for resident supervision, supervision documentation, and monitoring of resident supervision documentation.

The OIG identified deficits in the decision-making process to deactivate the patient's High Risk for Suicide PRF. VHA does not delineate requirements for the decision-making process to deactivate the High Risk for Suicide PRF; however, the Executive Director, Suicide Prevention Program shared with the OIG expectations that included consultation with the patient's treatment team, evidence of decreased risk and reduced suicide risk factors, and documented rationale for clinical judgment about mental health conditions and behaviors. These expectations were not met in the deactivation of the patient's High Risk for Suicide PRF in spring 2018. In order to provide guidance to all VHA facilities regarding High Risk for Suicide PRF deactivation, the OIG has directed a recommendation on this issue to the Executive in Charge, who has the authority to perform the function and duties of the Under Secretary for Health.

The OIG identified deficits in the emergency department pharmacist's medication reconciliation process. As part of the partial medication reconciliation process, the emergency department pharmacist did not review all medications with the patient and did not indicate that the patient self-discontinued two of the active medications on the imported medication list.

Recommendations 1–2

1. The Under Secretary for Health expedites the development of a National Suicide Prevention Program policy and procedure to delineate the deactivation process of High Risk for Suicide Patient Record Flags and monitors compliance.⁴⁹

⁴⁹ The recommendation directed to the Under Secretary for Health (USH) was submitted to the Executive in Charge who has the authority to perform the functions and duties of the USH.

2. The San Diego Healthcare System Director ensures that processes be strengthened to ensure accurate patient medication information is reflected in medication reconciliation documentation and monitors compliance.

Appendix A: Executive in Charge Comments

Department of Veterans Affairs Memorandum

Date: July 9, 2019

From: Executive in Charge, Office of the Under Secretary for Health (10N)

Subj: Healthcare Inspection—Alleged Deficiencies in Mental Health Care Prior to a Death by Suicide at the VA San Diego Healthcare System, California

To: Director, Office of Healthcare Inspections (54HL01)
Director, GAO/OIG Accountability Liaison (GOAL) Office (VHA 10EG GOAL Action)

1. Thank you for the opportunity to review and comment on the Office Inspector General (OIG) draft report Alleged Deficiencies in Mental Health Care Prior to a Patient's Death by Suicide at the VA San Diego Healthcare System.
2. The Veterans Health Administration (VHA) reviewed the OIG Draft Report, Alleged Deficiencies in Mental Health Care Prior to a Patient's Death by Suicide at the VA San Diego Healthcare System and concurs with the report and recommendation. While the circumstances surrounding the suicide of the Veteran were unfortunate, process review finds that adequate care was provided to the Veteran by the Emergency Department (ED), and the findings indicate no contributing factor in the death of the Veteran.
3. The ED staff recognized the Veteran as "High Risk" and implemented proper interventions for maximum safety. Proper assessment and documentation guidelines were followed that meet VHA and medical facility policies.
4. VHA agrees with the need to ensure that the completion of a medication reconciliation by the ED Pharmacist or ED Provider.
5. The Office of Emergency Medicine, in collaboration with the Office of Mental Health and Suicide Prevention and the Office of Veterans Access to Care, is working to expand tele-health capabilities in our Emergency Departments and Urgent Care Centers across the system to augment urgent care provided to Veterans.
6. If you have any questions, please email Karen Rasmussen, M.D., Director, GAO OIG Accountability Liaison Office at VHA10EGGOALAction@va.gov.

(Original signed by:)

Richard A. Stone, M.D.
Executive in Charge

Comments to OIG's Report

Recommendation 1

The Under Secretary for Health expedites the development of a National Suicide Prevention Program policy and procedure to delineate the deactivation process of High Risk for Suicide Patient Record Flags and monitors compliance.

Concur.

Target date for completion: December 2019

Executive in Charge Comments

To address the issue immediately, VHA's Office of Mental Health and Suicide Prevention will draft a VHA Notice (a controlled national policy) to clarify existing policy on the deactivation process for High Risk for Suicide Patient Record Flags. The VHA Notice will be published within 3 to 6 months, barring any unforeseen circumstances (legal and labor management delays), if any. VHA anticipates completion and distribution of the VHA Notice by December 2019.

Appendix B: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: July 9, 2019

From: Director, Desert Pacific Healthcare Network (VISN 22)

Subj: Healthcare Inspection—Alleged Deficiencies in Mental Health Care Prior to a Death by Suicide at the VA San Diego Healthcare System, California

To: Executive in Charge (10N)

1. I have reviewed and concur with the findings, recommendation, and action plan as submitted. The action plan will be followed through to completion and sustainment.
2. If you have any questions please contact the VISN 22 Acting QMO, Terri Elsholz at (480) 397-2782. Thank you.

(Original signed by:)

Michael W. Fisher
V22 Network Director

Appendix C: VA San Diego Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: June 11, 2019

From: Director, VA San Diego Healthcare System (664)

Subj: Healthcare Inspection— Alleged Deficiencies in Mental Health Care Prior to a Death by Suicide at the VA San Diego Healthcare System, California

To: Director, Desert Pacific Healthcare Network, (VISN 22)

1. In response to the report received as a result of the OIG Healthcare Inspection initiated on October 24, 2018 and site visit conducted at VA San Diego Healthcare System, January 8 – 10, 2019, the implementation plan addresses the findings and recommendation #2.
(See “Comments to OIG’s Report for Recommendation #2”)
2. I have reviewed and concur with the findings, recommendation and action plan as submitted. The action plan will be followed through to completion and sustainment to ensure that processes be strengthened to ensure accurate patient medication information is reflected in medication reconciliation documentation and monitors compliance.
3. Thank you.

(Original signed by:)

Robert M. Smith, MD
VASDHS Director

Comments to OIG's Report

Recommendation 2

The VA San Diego Healthcare System Director ensures that processes be strengthened to ensure accurate patient medication information is reflected in medication reconciliation documentation and monitors compliance.

Concur.

Target date for completion: 7/31/2019 and 12/31/2019

Director Comments

1. Education/Training for Pharmacy and Psychiatry Staff:
 - i. Pharmacy and Psychiatry staff will be educated on medication reconciliation (process and documentation), consistent with VHA directives and local policy. Education content will be designed to include elements that strengthen the quality of the Medication Reconciliation process, including how to document appropriately when patients report self-discontinuation of a prescribed medication on their list.
 - ii. Education will be provided through electronic communication as well as during pharmacy and medical staff meetings, and during the Chief of Psychiatry's Safety and Quality Rounds for Psychiatry Residents.
 - iii. Target Completion Date: 7/31/2019
2. Monitoring compliance:
 - i. Audits will be conducted of a random sample of 20 charts Emergency Department Psychiatry encounters per month for 4 consecutive months following education of Pharmacy and Psychiatry Staff. Audits will demonstrate 90% compliance with medication reconciliation.
 - ii. Target Completion Date: 12/31/2019

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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